INFORMATIONAL LETTER NO.1123

DATE: May 15, 2012

TO: Iowa Medicaid Optometrists and Opticians

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

SUBJECT: Third Party Liability (TPL) and Vision Claims

EFFECTIVE: Upon Receipt

This is to clarify the Medicaid policy for eyeglasses and contact lenses when a Medicaid member has third party vision insurance.

When a Medicaid member with third party vision insurance receives eyeglasses or contact lenses **covered by Medicaid**, the TPL insurer should be billed first. After the TPL insurer has settled their claim, a Medicaid claim should be submitted.

- If the TPL payment *exceeds* the Medicaid allowed amount, no further payment will be made by Medicaid. Per the Medicaid provider agreement, no further charge can be made to the Medicaid member or others. Only the $2.00 Medicaid co-pay amount can be charged to Medicaid members.
- If the TPL payment is *less than* the Medicaid allowed amount, Medicaid will pay the difference between what the TPL insurer has paid and the Medicaid allowed amount, less the $2.00 member co-pay.

Some vision insurers allow the beneficiary to choose whether to receive eyeglasses or contact lenses with their benefit. Medicaid does not have any restrictions that require a Medicaid member to use their third party vision benefits only for services otherwise covered by Medicaid. Because of this, a member may choose to receive contact lenses through their vision insurance and eyeglasses funded through Medicaid. Below are examples:

Example 1: A Medicaid member has vision insurance that will cover eyeglasses or contact lenses, but not both. The member does not meet the Medicaid criteria for contacts, but wants to use their vision insurance to pay for them. Medicaid regulations permit them to do so. Because the member does not meet the Medicaid criteria for contact lenses, they are considered a service not covered by Medicaid. The member is responsible to pay the provider any co-pay amount required under their third party vision insurance.

This same member also wants a pair of eyeglasses in addition to contact lenses. Because they have used their third party vision insurance benefit for contact lenses, and meet the Medicaid criteria for eyeglasses, they can receive eyeglasses funded by Medicaid. When billing Medicaid, the provider should indicate on the Medicaid claim that the carrier denied

coverage for the eyeglasses. The member is responsible to pay the $2.00 Medicaid co-pay amount to the provider in accordance with Medicaid co-pay requirements.

Example 2: A Medicaid member wants to receive two pairs of eyeglasses, one pair funded with their third party vision insurance and one pair funded by Medicaid. Unlike the contact lens example above, Medicaid does not have different criteria for coverage of eyeglasses. Only one pair is allowed. Because the member is using their third party vision insurance for a pair of eyeglasses, Medicaid will not cover a second pair of eyeglasses. The member is responsible to pay the provider the $2.00 Medicaid co-pay amount, in accordance with Medicaid co-pay requirements. They are not responsible to pay the third party insurance co-pay amount because the eyeglasses are a Medicaid covered service. Any amount up to the Medicaid fee schedule allowance not paid by the third party vision insurance should be billed to Medicaid.

Note: Vision coverage through third party insurers varies by individual policies, even though the insurance company may be the same. Medicaid vision providers must document denial of a benefit by a third party insurer either with a denied claim or documentation of the telephone contact regarding the coverage.

If you have any questions please contact the IME Provider Services Unit at 1-800-338-7909, or locally in Des Moines at 515-256-4609 or email at imeproviderservices@dhs.state.ia.us.